Principal
Item Rationale

2010 School Health Profiles Report
Item Rationale
Principal Survey

QUESTION:

1. Has your school ever used the School Health Index or other self-assessment tool to assess your school's policies, activities, and programs in the following areas?

RATIONALE:

This question assesses whether the school has conducted an assessment or diagnosis as a critical first step in improving implementation of policies, programs, or environmental strategies to effect change or improvement in school health.[1] Studies confirm that the School Health Index helps bring health issues to the school's attention, builds school commitment, identifies changes that do not require resources, encourages development of policy and action, raises awareness of federal policies, and helps schools set policies and standards that meet national health objectives.[2-6]

REFERENCES:

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4. Austin SB, Fung T, Cohen-Bearak A, Wardle K, Cheung LWY. Facilitating change in school health: a qualitative study of schools' experiences using the School Health Index. *Preventing Chronic Disease* [serial online]. 2006;3(2):A35.

5. Sherwood-Puzzello CM, Miller M, Lohrmann D, Gregory P. Implementation of CDC's School Health Index in 3 midwest middle schools: motivation for change. *Journal of School Health*. 2007;77:285-293.

6. Geiger BF, Petri CJ, Barber C. A university-school system partnership to assess the middle school health program. *American Journal of Health Studies.* 2004;19(3):158-163.

QUESTION:

2. The Elementary and Secondary Education Act requires certain schools to have a written School Improvement Plan (SIP). Many states and school districts also require schools to have a written SIP. Does your school's written SIP include health-related goals and objectives on any of the following topics?

RATIONALE:

This question assesses whether the school has a School Improvement Plan (SIP) that includes health-related goals and objectives. Education reform efforts are linked to student health; healthy students are present in school and ready to learn, while poor health is a barrier to learning and a frequent cause of underachievement.[1] In turn, academic success is an indicator of overall student well-being and a strong predictor of adult health outcomes.[2-5] A number of national education organizations recognize the close relationship between health and education and the need to embed health into the educational environment for all students.[6-11] Including health-related goals and objectives in a SIP can help ensure that health programs, which can have a positive impact on educational attainment and student health-risk behavior participation,[12-19] are present in schools.

REFERENCES:

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2. Grossman M, Kaestner R. Effects of education on health. In: Behrman JR, Stacey N, eds. *The Social Benefits of Education.* Ann Arbor: University of Michigan Press, 1997.

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14. Taras H. Nutrition and student performance at school. *Journal of School Health.* 2005;75(6):199–213.

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16. Taras H, Potts-Datema W. Childhood asthma and student performance at school. *Journal of School Health.* 2005;75(8):296–312.

17. Taras H, Potts-Datema W. Chronic health conditions and student performance at school. *Journal of School Health.* 2005;75(7):255–266.

18. Taras H, Potts-Datema W. Obesity and student performance at school. *Journal of School Health.* 2005;75(8):291–295.

19. Taras H, Potts-Datema W. Sleep and student performance at school. *Journal of School Health.* 2005;75(7):248–254.

QUESTION:

3. The Child Nutrition and WIC Reauthorization Act of 2004 requires school districts participating in federally subsidized child nutrition programs (e.g., National School Lunch Program or School Breakfast Program) to establish a local school wellness policy. Is your school required to report to your district each of the following types of information regarding implementation of the local wellness policy?

RATIONALE:

This item addresses the school-level reporting requirements of the district's wellness policy. According to the Child Nutrition and WIC Reauthorization Act of 2004, each school division that participates in the National School Lunch Program (NSLP) shall establish a local (school) wellness policy (LWP) no later than the first day of the school year beginning after June 30, 2006, to cover all NSLP schools in the school division.(1) To be in compliance, school districts are required to establish component goals for nutrition education, physical activity, and other school-based activities; establish nutrition guidelines for all foods available on the school campus; and assure that the U.S. Secretary of Agriculture's guidelines for federally reimbursable school meals are being met.(1) Currently, there exist no minimum national standards for policy components, such as the nutritional value of competitive foods or the amount of time devoted to physical activity, which in turn has led to the creation of some extremely weak policies and has created a national landscape with considerable variability among districts.(2) Given the potential impact of school health policies on physical activity, diet, and the availability of foods and beverages,(3,4) it is important to have a grasp of school-level reporting requirements for communities and for state education and health agencies to provide technical assistance for development, implementation, and evaluation.(2)

REFERENCES:

1. Child Nutrition and WIC Reauthorization Act of 2004. Public Law No. 108-265, 118 Stat. 730, § 204.

2. Story M, Nanney MS, Schwartz MB. Schools and obesity prevention: Creating school environments and policies to promote healthy eating and physical activity. *The Milbank Quarterly*. 2009;87(1):71–100.

3. French SA, Story M, Fulkerson JA, Gerlach AF. Food environment in secondary schools: a la carte, vending machines, and food policies and practices. *American Journal of Public Health.* 2003;93:1161-1167.

4. Davee AM, Blum JE, Devore RL, et al. The vending and a la carte policy intervention in Maine public high schools. *Preventing Chronic Disease* [serial online]. 2005;2(Special Issue):A14.

QUESTION:

4. Currently, does someone at your school oversee or coordinate school health and safety programs and activities?

RATIONALE:

This question assesses whether the school has identified a person responsible for coordinating a school's health program. It is critical to have one person appointed to oversee the school health program.[1] This individual coordinates school health activities, leads a school health committee or team, and integrates community-based programs with school-based programs.[2,3] Administration and management of school health programs requires devoted time, attention, training, and expertise.[4,5]

REFERENCES:

1. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.

2. Fetro JV. Implementing Coordinated School Health Programs in Local Schools. In: Marx E, Wooley S, eds. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York: Teachers College Press, 1998.

3. American Cancer Society. *School Health Program Elements of Excellence: Helping Children to Grow Up Healthy and Able to Learn*. Atlanta, GA: American Cancer Society, 2000.

4. National Association of State Boards of Education. *Fit, Healthy, and Ready to Learn: A School Health Policy Guide*. Washington, DC: NASBE, 2000.

5. American Cancer Society. *Improving School Health: A Guide to the Role of School Health Coordinator.* Atlanta, GA: American Cancer Society, 1999.

QUESTIONS:

5. Is there one or more than one group (e.g., a school health council, committee, or team) at your school that offers guidance on the development of policies or coordinates activities on health topics?

6. Are each of the following groups represented on any school health council, committee, or team?

RATIONALE:

These questions assess whether the school has a health committee or team and the composition of that team. The school health committee or team should represent a coalition of representatives from within and outside of the school community interested in improving the health of youth in schools.[1,2] Participation on such committees or teams can empower others through increased awareness and knowledge of the school health program, increase the chance of ownership and commitment, activate channels of communication, and increase involvement in decision making.[1-6] This includes parents and community members. Parent leaders help other parents understand and contribute ideas to issues and policies that affect the design and quality of school programs and opportunities for all children.[5]

REFERENCES:

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5. Redding S, Langdon J, Meyer J, Sheley P. *The Effects of Comprehensive Parent Engagement on Student Learning Outcomes.* Presentation at the Annual Convention of American Educational Research Association, San Diego, 2004.

6. Epstein LS. *School, Family, and Community Partnerships: Preparing Educators and Improving Schools*. Boulder, CO: Westview Press, 2001.

QUESTION:

7. Are any school staff required to receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on HIV, STD, or pregnancy prevention issues and resources for the following groups?

RATIONALE:

This question assesses professional development requirements for school staff on HIV, STD, and pregnancy prevention, specifically for youth at high risk. Youth at high risk include racial/ethnic minorities and those who participate in drop-out prevention, alternative education, or GED programs. Studies show that racial ethnic/minority students are more likely than white students to engage in sexual risk behaviors that can lead to HIV, STDs, and unintended pregnancy. For example, black, Hispanic/Latino, and American Indian students are more likely than white counterparts to have ever had sexual intercourse, to be currently sexually active (i.e., had sexual intercourse with 1 or more persons during the 3 months preceding the survey), to have had sexual intercourse before age 13 years, and to have had sexual intercourse with 4 or more persons during their life.[1-3] Additionally, the prevalence of these same sexual risk behaviors is higher among alternative high school students than among all high school students nationally, based on comparable estimates from the 1998 national Alternative High School Youth Risk Behavior Survey (ALT-YRBS) and 1997 Youth Risk Behavior Survey (YRBS).

As a result of differences in sexual behavior, high risk groups have different HIV, STD, and pregnancy prevention needs and health education and resources should be tailored to the specific population. Effective programs are appropriate for the age, sexual experience, gender, and culture of the youth.[5] Additionally, in order for such programs to be effective, educators must be trained to implement these programs with fidelity.[5] Professional development provides opportunities for educators to learn about new developments in the field and innovative teaching techniques, and to exchange ideas with colleagues.[6,7] Educators who have received professional development in health education report increases in the number of health lessons taught and their confidence in teaching.[8]

REFERENCES:

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4. CDC. Youth Risk Behavior Surveillance – National Alternative High School Youth Risk Behavior Survey, United States, 1998. *MMWR.* 1999;48(SS-7):1-44.

5. Kirby D, Laris BA, Rolleri L. *Sex and HIV education programs for youth: Their impact and important characteristics*. Washington DC: Family Health International, 2006. Available at: http://www.fhi.org/NR/rdonlyres/eg6dcdnypfc6lbcdq2jccju67o644svf3npgjtuagpsdimlkx7edlrojytwevjznjsfnkqflbak4hj/SexandHIVEducationProgramsKirby.pdf. Accessed June 11, 2009.

6. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.

7. National Association of State Boards of Education (NASBE) & National School Boards Association (NSBA). *HIV Prevention in Schools: A Tool Kit for Education Leaders*. 2002. Available at: http://nasbe.org/index.php/file-repository?func=startdown&id=787. Accessed June 12, 2009.

8. Hausman A, Ruzek S. Implementation of comprehensive school health education in elementary schools: focus on teacher concerns. *Journal of School Health.* 1995;65(3):81-86.

QUESTION:

8. Does your school have a student-led club that aims to create a safe, welcoming, and accepting school environment for all youth, regardless of sexual orientation or gender identity? These clubs sometimes are called gay/straight alliances.

RATIONALE:

This question assesses whether the school has a gay/straight alliance or similar student-led club. Such clubs are critical to the well-being of students. Students in schools with a gay/straight alliance are less likely to feel unsafe at school, less likely to miss school, and more likely to feel like they belong at their school than students in schools with no such clubs.[(1)]

REFERENCE:

1. Kosciw JG, Diaz EM, Greytak EA. *2007 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools*. New York: GLSEN, 2008. Available at: http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/000/001/1290-1.pdf. Accessed June 11, 2009.

QUESTION:

9. Does your school engage in each of the following practices related to lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth?

RATIONALE:

This question assesses whether the school includes activities and policies designed to create a safe school climate for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. A safe school climate is critical to the well-being and academic success of all students. A majority of teachers feel they have a responsibility to provide a safe environment for LGBTQ students. [I] In addition, students from schools with a policy that includes sexual orientation or gender report fewer problems with school safety in general.[I]

REFERENCE:

1. Harris Interactive and GLSEN. *From Teasing to Torment: School Climate in America, A Survey of Students and Teachers*. New York: GLSEN, 2005. Available at: http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/499-1.pdf. Accessed June 11, 2009.

QUESTION:

10. Has your school adopted a policy that addresses each of the following issues on human immunodeficiency virus (HIV) infection or AIDS?

RATIONALE:

This question assesses important components of school policies in place to address students and staff infected with HIV or AIDS. Students and staff infected with HIV or AIDS need policies protecting their rights.[1]

REFERENCE:

1. National Association of State Boards of Education. *Someone at school has AIDS: a complete guide to education policies concerning HIV infection*. Alexandria, VA: National Association of State Boards of Education, 2001. Available at: http://www.nasbe.org/index.php/component/content/article/78-model-policies/120-policies-concerning-students-and-staff-with-hiv-infection. Accessed June 11, 2009.

QUESTION:

11. Does your school have or participate in each of the following programs?...A student mentoring program? A safe-passages to school program? A program to prevent bullying? A program to prevent dating violence? A youth development program?

RATIONALE:

These questions measure whether or not various injury prevention programs are being implemented. The Safe and Drug-Free School and Communities Act of 1994 provides federal funds for programs to prevent violence in and around schools.[1] Some evidence has demonstrated that students who participate in mentoring programs are less likely than their non-mentored peers to be involved in bullying or fighting, especially when such programs are implemented with at-risk youth.[2,3] Bullying prevention programs have also demonstrated effectiveness in decreasing levels of victimization. Programs that were most likely to be effective were those that were comprehensive and included elements such as parent training, improved playground supervision, and classroom management.[4,5] At least one dating violence prevention program has demonstrated effectiveness in decreasing rates of physical, serious physical, and sexual dating violence perpetration and victimization; moreover, these effects were maintained up to 4 years after program implementation.[6,7] Similarly, youth development programs have also demonstrated a positive impact on violence-related outcomes. For example, young people who participated in the Seattle Social Development program during their elementary school years were significantly less likely to be involved in a high variety of crime, to have sold illegal drugs in the past year, and to have an official lifetime court record at age 21.[8]

REFERENCES:

1. Safe and Drug-Free Schools and Communities Act. 20 U.S.C. § 7101 et seq., 2005.

2. King KA, Vidourek RA, Davis B, McClellan W. Increasing self-esteem and school connectedness through a multidimensional mentoring program. *Journal of School Health.* 2002;72:294-299.

3. DuBois DL, Holloway BE, Valentine JC, Cooper H. Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology.* 2002;30(2):157-197.

4. Ttofi MM, Farrington DP, Anna C. Baldry AC for the Swedish National Council for Crime Prevention. *Effectiveness of Programs to Reduce School Bullying*. Edita Norstedts Vasteras, 2008.

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8. Hawkins JD, Kosterman R, Catalano RF, Hill KG, Abbott RD. Promoting positive adult functioning through social development intervention in childhood. *Archives of Pediatrics & Adolescent Medicine.* 2005;159:25-31.

QUESTION:

12. Are all staff who teach health education topics at your school certified, licensed, or endorsed by the state in health education?

RATIONALE:

This question addresses the necessary qualifications of staff who teach health education. The National Commission for Health Education Certification, Inc. supports Certified Health Education Specialists (CHES). CHES teachers are more likely than non-CHES teachers to teach about HIV and sexually transmitted disease prevention.[1] Studies in other disciplines reveal that nationally certified teachers, to a greater degree than non-certified teachers, possess pedagogical content knowledge that is more flexibly and innovatively employed in instruction; are more able to improvise and to alter instruction in response to contextual features of the classroom situation; understand at a deeper level the reasons for individual student success and failure on any given academic task; are more able to provide developmentally appropriate learning tasks that engage, challenge, and even intrigue students; are more able to anticipate and plan for difficulties students are likely to encounter with new concepts; are more easily able to improvise when things do not run smoothly; are more able to generate accurate hypotheses about the causes of student success and failure; and bring a distinct passion to their work.[2] The leading national organizations supporting school health education, including the American School Health Association and the American Association for Health Education, recommend that those who teach health education have professional preparation and state certification in health education.[3,4] The Joint Committee on National Health Education Standards recommends that local education agencies ensure that health education is taught by licensed/certified health education teachers with training in implementing the National Health Education Standards.[5]

REFERENCES:

1. Jones SE, Brener ND, McManus T. The relationship between staff development and health instruction in schools in the United States. *American Journal of Health Education.* 2004;35:2-10.

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4. American School Health Association. *ASHA Resolutions: Certification*. 2002. Available at: http://www.ashaweb.org/files/public/Resolutions/Certification.pdf. Accessed June 11, 2009.

5. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2nd Edition).* Atlanta: American Cancer Society, 2007.

REQUIRED PHYSCIAL EDUCATION

QUESTIONS:

13. Is physical education required for students in any of grades 6 through 12 in your school?

14. Is a required physical education course taught in each of the following grades in your school?

RATIONALE:

These questions measure the extent to which physical education is required for students in grades 6 through 12. Physical education provides students with the knowledge, attitudes, skills, behaviors, and confidence to adopt and maintain physically active lifestyles.[1,2] The importance of physical education in promoting the health of young people is supported by *Healthy People 2010* Objectives 22-8, 22-9, and 22-10.[3]

REFERENCES:

1. National Association for Sport and Physical Education. *Moving into the Future: National standards for physical education.* 2nd ed. Reston, VA: National Association for Sport and Physical Education, 2004.

2. Lee SM, Burgeson CR, Fulton JE, Spain CG. Physical education and activity: results from the School Health Policies and Programs Study 2006. *Journal of School Health.* 2007;77(8):435-463.

3. U.S. Department of Health and Human Services. *Healthy People 2010*. 2nd ed. with *Understanding and Improving Health and Objectives for Improving Health*, 2 vols. Washington, DC: U.S. Department of Health and Human Services, 2000.

QUESTION:

15. Can students be exempted from taking required physical education for one grading period or longer for each of the following reasons?

RATIONALE:

This question examines whether students are allowed to be exempt from physical education based upon participation in non-physical activities or interscholastic sports. Exemptions from required physical education do not allow students to participate in comprehensive, standards-based physical education; this practice diminishes the importance of physical education and its role in assisting students with establishing physically active lifestyles and developing various motor, movement, and behavioral skills unique to being physically educated.(1)

REFERENCE:

1. National Association for Sport and Physical Education. *Opposing substitution and waiver/exemption for required physical education.* Reston, VA: National Association for Sport and Physical Education, 2006. Available at: http://www.aahperd.org/naspe/pdf_files/pos_papers/OpposingSubstitutionWaiverExemptions.pdf. Accessed June 11, 2009.

PHYSICAL EDUCATION AND PHYSICAL ACTIVITY

QUESTION:

16. During the past two years, did any physical education teachers or specialists at your school receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on physical education?

RATIONALE:

This question examines professional development for PE teachers. Physical education teachers should have professional development opportunities that teach concepts of quality physical education instruction. PE teachers who participate in staff development programs are more likely to use recommended teaching methods such as holding group discussions, implementing physical activity stations, videotaping student performances, testing students' knowledge related to PE, giving fitness tests, and explaining to students the meaning of fitness scores.[1-3] Professional development for PE teachers provides skills to increase the quality of PE classes through student engagement in physical activity and the content of lessons taught.[4-6]

REFERENCES:

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5. Kelder S, Mitchell PD, McKenzie TL, et al. Long-term implementation of the CATCH physical education program. *Health Education and Behavior.* 2003;30(4):463-475.

6. McKenzie TL, Marshall SJ, Sallis JF, Conway TL. Student activity levels, lesson context, and teacher behavior during middle school physical education. *Research Quarterly for Exercise and Sport.* 2000;71(3):249-259.

QUESTION:

17. Are those who teach physical education at your school provided with each of the following materials?

RATIONALE:

This question measures the type of information and support materials PE teachers are given in order to implement PE classes. According to NASPE, quality physical education is guided by and should include a written PE curriculum; goals, objectives, and expected outcomes; scope and sequence of instruction for PE; and plans for age-appropriate student assessment.[1-3]

REFERENCES:

1. National Association for Sport and Physical Education. *Moving into the future: National standards for physical education*. Reston, VA: National Association for Sport and Physical Education, 2004.

2. National Association for Sport and Physical Education. *What constitutes a quality physical education program?* Reston, VA: National Association for Sport and Physical Education, 2003. Available at: http://www.aahperd.org/naspe/pdf_files/pos_papers/qualityPePrograms.pdf. Accessed June 11, 2009.

3. Centers for Disease Control and Prevention. *Physical Education Curriculum Analysis Tool.* Atlanta, GA: U.S. Department of Health and Human Services, 2006.

QUESTION:

18. Does your school offer opportunities for students to participate in intramural activities or physical activity clubs? (Intramural activities or physical activity clubs are any physical activity programs that are voluntary for students, in which students are given an equal opportunity to participate regardless of physical ability.)

RATIONALE:

This question measures the extent to which students are provided the opportunity to participate in physical activities outside of the regular school day. According to NASPE, intramural activities, physical activity clubs, and recreation clubs contribute to young people's physical and social development. Additionally, intramural activities or physical activity clubs offer students the opportunity to be involved in planning and implementing such programs and offer safe and structured opportunities to be physically active.[1-6]

REFERENCES:

1. National Association for Sport and Physical Education. *Guidelines for after-school physical activity and intramural programs.* Reston, VA: National Association for Sport and Physical Education, 2002. Available at http://www.aahperd.org/naspe/pdf_files/pos_papers/intramural_guidelines.pdf. Accessed June 11, 2009.

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3. Kelder S, Hoelscher DM, Barroso CS, et al. The CATCH Kids Club: a pilot after-school study for improving elementary students' nutrition and physical activity. *Public Health Nutrition.* 2005;8(2):133-40.

4. Pate RR, Saunders RP, Ward DS, Felton G, Trost SG, Dowda M. Evaluation of a community-based intervention to promote physical activity in youth: lessons from Active Winners. *American Journal of Health Promotion.* 2003;17(3):171-82.

5. Trevino RP, Yin Z, Hernandez A, Hale DE, Garcia OA, Mobley C. Impact of the Bienestar school-based diabetes mellitus prevention program on fasting capillary glucose levels: a randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine.* 2004;158(9):911-7.

6. Pate RR, O'Neill JR. After-school interventions to increase physical activity among youth. *British Journal of Sports Medicine.* 2009;43:14-18.

QUESTION:

19. Outside of school hours or when school is not in session, do children or adolescents use any of your school's indoor physical activity or athletic facilities for community-sponsored physical activity classes or lessons?

RATIONALE:

This question measures the extent to which students have access to the school's facilities for sports teams or other physical activity programs. School spaces and facilities should be available to young people before, during, and after the school day, on weekends, and during summer and other vacations. Access to these facilities increases visibility of schools, provides youth, their families, and community members a safe place for physical activity, and might increase partnerships with community-based physical activity programs. Community resources can expand existing school programs by providing program staff as well as intramural and club activities on school grounds. For example, community agencies and organizations can use school facilities for after-school physical fitness programs for children and adolescents, weight

management programs for overweight or obese young people, and sports and recreation programs for young people with disabilities or chronic health conditions.[1-3]

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TOBACCO-USE PREVENTION POLICIES

QUESTIONS:

20. Has your school adopted a policy prohibiting tobacco use?

21. Does the tobacco-use prevention policy specifically prohibit use of each type of tobacco for each of the following groups during any school-related activity?

22. Does the tobacco-use prevention policy specifically prohibit tobacco use during each of the following times for each of the following groups?

23. Does the tobacco-use prevention policy specifically prohibit tobacco use in each of the following locations for each of the following groups?

24. Does your school have procedures to inform each of the following groups about the tobacco-use prevention policy that prohibits their use of tobacco?

25. Does your school's tobacco-use prevention policy include guidelines on what actions the school should take when students are caught smoking cigarettes?

26. At your school, who is responsible for enforcing your tobacco-use prevention policy?

27. Do each of the following criteria help determine what actions your school takes when students are caught smoking cigarettes?

28. When students are caught smoking cigarettes, how often are each of the following actions taken?

29. Does your school post signs marking a tobacco-free school zone, that is, a specified distance from school grounds where tobacco use is not allowed?

RATIONALE:

These questions measure the extent to which schools develop, implement, and enforce a policy that creates a totally tobacco-free environment within the school experience for both young people and adults, as outlined in the CDC *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*[1] to achieve the *Healthy People 2010* Objective 27-11 of creating smoke-free and tobacco-free schools.[2] The Pro-Children Act of 1994, reauthorized under the No Child Left Behind Act of 2001, prohibits smoking in facilities where federally funded educational, health, library, daycare, or child development services are provided to children under the age of 18.[3,4]

Because tobacco use is the most preventable contributor to mortality in the United States, it is important to restrict use or exposure to tobacco products at an early age.[1] The existence and enforcement of a school policy creates a tobacco-free environment that models acceptable behavior and sends a clear message to students, teachers, staff, parents, and visitors that the use of tobacco is socially unacceptable.[5] Environmental interventions aimed at reducing use of tobacco in homes, public places, and worksites lead to reduction of tobacco use.[6] Likewise, tobacco-free school policies are associated with lower rates of student smoking.[5,7-9]

Prohibiting any use of any tobacco product at all times, whether or not school is in session, and regardless of whether students are present, protects students and staff from the harmful effects of secondhand smoke (a mixture of smoke from the burning end of tobacco products and the smoke exhaled by smokers). The 2006 U.S. Surgeon General's report, *The Harmful Effects of Involuntary Exposure to Tobacco Smoke*, outlines a large body of research findings which demonstrate that breathing secondhand smoke is harmful to health.[10] Evidence shows that there is no safe level of secondhand smoke exposure, and even the most advanced ventilation systems cannot eliminate secondhand smoke or its harmful effects.[10] A complete ban of indoor smoking at all times in a facility (such as a school building) is the only effective approach to controlling involuntary inhalation of secondhand smoke.[10]

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QUESTION:

30. During the past two years, has your school done each of the following activities?…Gathered and shared information with students and families about mass-media messages or community-based tobacco-use prevention efforts? Worked with local agencies or organizations to plan and implement events or programs intended to reduce tobacco use?

RATIONALE:

This question measures the extent to which the school coordinates its efforts with other tobacco-use prevention efforts in the community that target young people. CDC's *Best Practices for Comprehensive Tobacco Control Programs—2007* provides evidence-based guidance to assist in planning and establishing comprehensive and effective tobacco control programs that include efforts to prevent youth initiation and reduce youth tobacco use.[(1)] School programs can be effective, but maintaining those effects presents a challenge, especially with the many other influences encouraging tobacco use originating outside of the school environment. The strongest evidence of success for school-based tobacco-use prevention efforts has been shown with those that are coordinated or delivered in conjunction with mass media and community tobacco control

efforts, creating an environment of support for a tobacco-free lifestyle and delivering messages that are mutually reinforced.[1] The Surgeon General has reported that 20-40% of tobacco use by youth can be prevented by educational strategies conducted in conjunction with community- and media-based activities.[2] In 2004, the Task Force for the Community Guide to Preventive Services found "strong evidence for the use of school-based interventions when delivered in conjunction with mass media and community activities."[3] The Task Force recommendations were based on a subset of studies that showed evidence in reducing tobacco use among youth when multiple channels were used to support the in-school health education efforts. Receiving consistent messages across community contexts and over time has been shown to enhance the maintenance of health education program effects.[4,5]

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QUESTION:

31. Does your school provide tobacco cessation services for each of the following groups?

32. Does your school have arrangements with any organizations or health care professionals not on school property to provide tobacco cessation services for each of the following groups?

RATIONALE:

These questions measure the extent to which schools provide access to tobacco-use cessation services, as outlined in the *CDC Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*[1] to achieve the *Healthy People 2010* Objectives 27-5 and 27-7 of increasing tobacco-use cessation attempts among adult and adolescent smokers.[2] Nicotine addiction can occur at an early age for some adolescent tobacco users.[3] People who begin using tobacco at an early age are more likely to develop higher levels of addiction in adulthood.[3] Adolescent tobacco users suffer similar symptoms of withdrawal to those of adults when attempting to quit.[4] Many young people want to quit but have tried and failed.[5] Some are unaware of or do not have access to cessation services. Others underestimate the power of addiction and do not feel that quitting would require professional assistance; therefore recruitment into formal programs can be difficult.[6] School health providers as a routine part of care should assess the tobacco-use status of students, and if they identify a student's use of tobacco, they should provide self-help materials and refer them to a tobacco-use cessation program provided on site or in the community.[7-9] Also, providing a brief clinical intervention has been shown to encourage cessation among both adults and adolescents.[9]

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NUTRITION-RELATED POLICIES AND PRACTICES

QUESTIONS:

33. When foods or beverages are offered at school celebrations, how often are fruits or non-fried vegetables offered?

34. Can students purchase snack foods or beverages from one or more vending machines at the school or at a school store, canteen, or snack bar?

35. Can students purchase each of the following snack foods or beverages from vending machines or at the school store, canteen, or snack bar?

36. Does your school limit the package or serving size of any individual food and beverage items sold in vending machines or at the school store, canteen, or snack bar?

RATIONALE:

These questions address the extent to which schools are making more nutritious foods available to students, limiting portion sizes, and not offering less nutritious foods and beverages. Many schools offer foods and beverages in after-school programs, school stores, snack bars, or canteens[1] and these foods sold in competition to school meals are often relatively low in nutrient density and relatively high in fat, added sugars and calories.[2] Competitive foods are widely available in many elementary schools, in most middle schools, and in almost all secondary schools.[1,3,4] Given that schools offer numerous and diverse opportunities for young people to learn and make consumption choices about healthful eating, schools should provide a consistent environment that is conducive to healthful eating behaviors.[5] To help improve dietary behavior and reduce overweight among youths, schools should offer appealing and nutritious foods in school snack bars and vending machines and discourage sale of foods high in fat, sodium, and added sugars, and beverages and foods containing caffeine on school grounds.[6-8] Because students' food choices are influenced by the total food environment, the simple availability of healthful foods such as fruits and vegetables may not be sufficient to prompt the choice of fruits and vegetables when other high-fat or high-sugar foods are easily accessible.[9,10]

However, offering a wider range of healthful foods can be an effective way to promote better food choices among high school students.[11] Taken together, such findings suggest that restricting the availability of high-calorie, energy dense foods in schools while increasing the availability of healthful foods might be an effective strategy for promoting more healthful choices among students at school.[5]

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QUESTION:

37. During this school year, has your school done any of the following?...Priced nutritious foods and beverages at a lower cost while increasing the price of less nutritious foods and beverages? Collected suggestions from students, families, and school staff on nutritious food preferences and strategies to promote healthy eating? Provided information to students or families on the nutrition and caloric content of foods available? Conducted taste tests to determine food preferences for nutritious items? Provided opportunities for students to visit the cafeteria to learn about food safety, food preparation, or other nutrition-related topics?

RATIONALE:

This question addresses the variety of methods schools can use to promote healthy eating. Students' food choices are influenced by the total food environment. The simple availability of fruits and vegetables may not be sufficient to prompt the choice of these items when items high in fat and/or added sugar are also available.[1] Even when fruit and vegetable items are available, they compete in the context of a vast array of other food items, mostly high in fat and sugar, that are competitively priced.[2] Schools should employ effective or promising strategies in the school setting to promote healthy eating, such as pricing strategies,[3,4] input from stakeholders,[5] provision of nutrition information,[6] taste tests, and using the cafeteria as a learning laboratory.[7]

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QUESTIONS:

38. At your school, are candy, meals from fast food restaurants, or soft drinks promoted through the distribution of products, such as t-shirts, hats, and book covers to students?

39. Does your school prohibit advertisements for candy, fast food restaurants, or soft drinks in each of the following locations?

RATIONALE:

These questions addresses prohibiting marketing of less nutritious foods to students while at school or at school-sponsored events. In 2006, 23.3% of schools allowed the promotion of candy, meals from fast food restaurants, or soft drinks through the distribution of coupons for free or reduced price, 14.3% allowed the promotion of these products through sponsorship of school events, and 7.7% did so through publications such as a school newsletter or newspaper.[1] Many contracts for soft drink or other vending products have provisions to increase the percentage of profits schools receive when sales volume increases, and this is a substantial incentive for schools to promote soft drink consumption by adding vending machines, increasing the times they are available, and marketing the products to students.[2,3] In some districts, these incentives have led schools to aggressively promote student purchases of soft drinks.[4] Research suggests that exposure to advertisements may have adverse effects on children's eating habits.[5] Food advertisements have been found to trigger food purchase by parents, have effects on children's product and brand preferences, and have an effect on consumption behavior.[6] Further, younger children do not generally understand the difference between information and advertising,[7] such that children may interpret school-based advertising to mean that teachers or other adults endorse the use of the advertised product. Given that schools provide a captive audience of students, the

Institute of Medicine (IOM) report on food marketing to children and youth recommends that schools should promote healthful diets for children and youth in all aspects of the school environment (e.g., commercial sponsorships, meals and snacks, curriculum), and outlines the importance of prohibiting advertising of less nutritious foods.[8]

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HEALTH SERVICES

QUESTION:

40. Is there a full-time registered nurse who provides health services to students at your school? (A full-time nurse means that a nurse is at the school during all school hours, 5 days per week.)

RATIONALE:

This question examines the degree to which schools are being adequately staffed by school nurses. Because a school nurse is an essential component of a healthy school, *Healthy People 2010* Objective 7-4 calls to increase the proportion of elementary, middle, and senior high schools with a nurse-to-student ratio of 1:750.[1] School nurses can link students and schools to physician and community resources.

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QUESTION:

41. At your school, how many students with known asthma have an asthma action plan on file? (Students with known asthma are those who are identified by the school to have a current diagnosis of asthma as reported on student emergency cards, medication records, health room visit information, emergency care plans, physical exam forms, parent notes, and other forms of health care clinician notification.)

RATIONALE:

This question addresses the need for clear, written guidance about the needs of individual students with asthma. Assessment of successful school-based asthma management programs suggest these plans play an important role in providing school staff, students, and families with an understanding of an individual student's asthma management needs at school, including how to respond in an emergency. Additionally, the use of an asthma action plan at school results in affected students experiencing significant improvement in several health-related outcomes, including a decrease in the frequency of asthma-related nighttime awakenings, number of days of restricted activity, and frequency of acute medical treatment.[1,2] Schools should have asthma action plans on file for all students with known asthma. These plans help schools meet the needs of students with asthma during the school day and at school-related activities. Based upon current research, federal agencies and other national organizations have provided additional guidance and recommendations related to the collection and implementation of individualized

plans. Plans should be developed by a primary care provider and be provided by parents. They should include individualized emergency protocol, medications, environmental triggers and emergency contact information. School staff should actively solicit copies of asthma action plans from families and/or asthma care providers. When necessary, school nurses can construct asthma action plans based on information from the family and medication orders. A constructed plan should be sent to the asthma care provider for confirmation that it is appropriate.[3-7]

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QUESTION:

42. At your school, which of the following events are used to identify students with poorly controlled asthma?

RATIONALE:

This question examines the type of information schools use to monitor and then assess the need for additional case management of students with known asthma. Assessment of successful school-based asthma management programs reveal that this type of tracking and case management can contribute to the medical management of students with asthma.[1-4] This information can subsequently be used by schools to focus their asthma programs on students with poorly managed asthma as demonstrated by frequent school absences, school health office visits, emergency department visits, or hospitalizations.[5,6]

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QUESTION:

43. Does your school provide each of the following services for students with poorly controlled asthma?

RATIONALE:

This question examines whether schools provide intensive case management for students with poorly controlled asthma. Schools should ensure that case management is provided by a trained professional for students with frequent school absences, school health office visits, emergency department visits, or hospitalizations due to asthma.[1-7] Assessment of successful school-based asthma management programs reveal that monitoring and then providing case management can contribute to the medical management of students with asthma.[3,8] Case management activities help students better manage their asthma, and have been shown to decrease hospitalizations, emergency department visits, and school absences among students with severe, persistent, or poorly controlled asthma.[9,10]

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QUESTION:

44. How often are school staff members required to receive training on recognizing and responding to severe asthma symptoms?

RATIONALE:

This question examines professional development for school staff. Because asthma can be life-threatening, it is essential to assist those involved in monitoring and managing children with asthma at school to provide timely, appropriate care. Therefore, all school staff members should be provided with basic information about asthma so that they can support students' asthma management and appropriately respond to asthma emergencies.[1-7]

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QUESTIONS:

45. Has your school adopted a policy stating that students are permitted to carry and self-administer asthma medications?

46. Does your school have procedures to inform each of the following groups about your school's policy permitting students to carry and self-administer asthma medications?

47. At your school, who is responsible for implementing your school's policy permitting students to carry and self-administer asthma medication?

RATIONALE:

These questions address the need for schools to have policies and procedures to support students in receiving the asthma medications they may need at school. Many students with asthma require preventive or quick-relief medicine at school. Students with asthma have had serious episodes and have died at school when they did not have access to quick-relief medicine.[1] Access to medications is critical and it must meet usual safety guidelines for medication storage.[2,3] To ensure compliance with federal, state, and many local laws and guidelines, schools should ensure that students have immediate access to asthma medications, as prescribed by a physician and approved by parents.[4] Several national guidance documents, along with evaluations of successful school-based asthma programs, have provided additional information that addresses the process and methods for self-carry policies. Policies should include medication storage in a safe, controlled, and accessible location, and appropriate attention should be given to expiration dates and safe disposal.[5-8]

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FAMILY AND COMMUNITY INVOLVEMENT

QUESTION(S):

48. During the past two years, have students' families helped develop or implement policies and programs related to each of the following topics?

49. During the past two years, have community members helped develop or implement policies and programs related to each of the following topics?

RATIONALE:

These questions emphasize the importance of engaging family and community members in school health programs. Parent leaders help other parents understand and contribute ideas to issues and policies that affect the design and quality of school programs and opportunities for all children.[1] School programs that engage parents and link with the community yield stronger positive results. Studies aimed at preventing childhood overweight, treating childhood overweight, or promoting physical activity and healthy eating have demonstrated more success when targeting the parent and child versus targeting the child alone.[2,3] School-based tobacco prevention programs and community interventions involving parents and community

organizations have a stronger impact over time when working in tandem rather than as separate, stand-alone interventions.[4] Collaboration with parent groups, community organizations, and other agencies can help to build broad-based support for school health programs, especially when they address topics that can be emotionally charged, such as HIV, other STD, and pregnancy prevention.[5] Without parental support of HIV, other STD, and pregnancy prevention education programs and policies, they cannot be sustained.[5-7] Collaborative asthma interventions require a team effort and involve the whole school community: school administrators, faculty, and staff, as well as students, parents, and local community organizations.[8,9]

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